Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOTEXAS PHYSICIANS & SURGEONS
4780 NORTH JOSEY LANE
CARROLLTON TX 75010

Respondent Name
OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box
Box Number 44

MFDR Tracking Number
M4-12-2244-01

MFDR Date Received
FEBRUARY 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Insurance denied for timely filing I appealed with proof and then they denied as duplicate."

Amount in Dispute: $1,844.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 9, 2011	CPT Code 27698-AS-RT	$625.41	$88.45
	CPT Code 29891-AS-RT	$665.54	$188.51
	CPT Code 29898-AS-RT	$553.76	$78.32
TOTAL		$1,844.71	$355.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.027, titled *PAYMENT OF HEALTH CARE PROVIDER*, effective September 1, 2005, sets out deadline for timely submitting the medical bills to the insurance carrier.
3. 28 Texas Administrative Code § 102.4(h), titled *General Rules for Non-Commission Communication*, effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §133.20, titled *Medical Bill Submission by Health Care Provider*, effective May

2, 2006, sets out the timeframe for healthcare providers to submit a medical bill.

5. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - 29-The time limit filing has expired.
   - 937-Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
   - 18-Duplicate claim/service.
   - 247-A payment or denial has already been recommended for this service.
   - 306-Billing is a duplicate of other services performed on same day.

Issues

1. Does the documentation support that bill was timely filed?
2. Is the requestor entitled to reimbursement for CPT code 27698-AS-RT?
3. Is the requestor entitled to reimbursement for CPT code 29891-AS-RT?
4. Is the requestor entitled to reimbursement for CPT code 29898-AS-RT?

Findings

1. Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 Texas Administrative Code §133.20(b) states "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   (1) the date received, if sent by fax, personal delivery or electronic transmission or,

   (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   The requestor states that "Insurance denied for timely filing I appealed with proof and then they denied as duplicate."

   The requestor submitted a copy of a Claim History report that supports that on 06/22/2011 the carrier confirmed receipt of medical bill.

   The Division finds that the requestor supported position that the disputed bill was submitted timely in accordance with Texas Labor Code §408.027(a) and 28 Texas Administrative Code §133.20(b). Therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. CPT code 27698 is defined as "Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)."

   A review of the medical bill indicates that the services were performed by a PAC.

   28 Texas Administrative Code §134.203 (b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Per CMS policy "The allowable for the assistant-at-surgery services performed by an NP, PA or CNS is 85 percent of the 16 percent allowed based on the physician fee schedule."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services,

system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2011 DWC conversion factor for this service is 68.47.

The Medicare Conversion Factor is 33.9764

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75010, which is located in Denton County.

The Medicare participating amount for code 27698 in Denton County is $645.47.

This code is subject to multiple procedure rule discounting.

Using the above formula, the MAR is $650.38.

The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the Physician Assistant that assistant at surgery receives 85 percent of 16 percent of the MAR = $88.45. The respondent paid $0.00. The requestor is due $88.45 additional reimbursement.

3. CPT code 29891 is defined as "Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect."

   The 2011 DWC conversion factor for this service is 68.47.

   The Medicare Conversion Factor is 33.9764

   The Medicare participating amount for code 29891 in Denton County is $687.84.

   Because it has the highest value, this is considered primary procedure; therefore, exempt from multiple procedure rule discounting.

   Using the above formula, the MAR is $1386.15.

   The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the Physician Assistant that assistant at surgery receives 85 percent of 16 percent of the MAR = $188.51. The respondent paid $0.00. The requestor is due $188.51 additional reimbursement.

4. CPT code 29898 is defined as "Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive."

   The 2011 DWC conversion factor for this service is 68.47.

   The Medicare Conversion Factor is 33.9764

   The Medicare participating amount for code 29898 in Denton County is $571.60.

   This code is subject to multiple procedure rule discounting.

   Using the above formula, the MAR is $575.95.

   The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the Physician Assistant that assistant at surgery receives 85 percent of 16 percent of the MAR = $78.32. The respondent paid $0.00. The requestor is due $78.32 additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $355.28.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $355.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/20/2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.